



THOMAS L. GARTHWAITE, M.D. Director and Chief Medical Officer

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Chief Operating Officer

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March 2, 2004

TO:

Each Supervisor

FROM:

Thomas L. Garthwaite, MD

Director and Chief Medical Officer

SUBJECT: AFFILIATION AGREEMENTS AND CLINICAL REDESIGN

This report is in response to requests by members of your Board regarding the Department's efforts to renegotiate our affiliation agreements while simultaneously continuing to pursue the redesign and, in some cases, consolidation of clinical services. Supervisor Antonovich requested that the Department report back to the Board regularly on the six questions for negotiations that I mentioned in my Board memo dated February 2, 2004. Supervisor Molina requested that the Department of Health Services (DHS) provide the Board with a written report regarding issues in negotiations with USC and UCLA. Supervisor Yaroslavsky requested details on the likelihood of success of the renegotiation of the Affiliation Agreement with Drew University and on what the Department's options are at King/Drew Medical Center if the renegotiation fails.

On February 18, 2004, Dr. Robert L. Waters, Interim Senior Medical Director, Clinical Affairs and Affiliations, chaired a meeting of the Joint Planning Operations Committee. Representatives from USC, UCLA, and Drew were present in addition to the DHS Medical Directors and CEOs. Dr. Waters shared with the group copies of my February 2, 2004 Board memo and informed the group that we had entered into our renegotiation of the Drew Affiliation Agreement with a short timeline. He also notified them that we will concurrently start meeting with officials from USC and UCLA.

Based on input regarding key renegotiation issues from your Board, our CEOs and Medical Directors, Senior Managers representing Public Health, the CAO, County Counsel, and the Auditor-Controller, we have developed a framework of issues for our negotiations with each university that includes the following elements (shown in more detail in Attachment I):

- Value of services provided and incentives for education and clinical care
- Contract oversight

Gloria Molina First District

Yvonne Brathwaite Burke Second District

> Zev Yaroslavsky Third District

Don Knabe Fourth District

Michael D. Antonovich Fifth District Each Supervisor March 5, 2004 Page 2

- · Determination of number of residency slots and supported programs
- Communications
- Term of affiliation agreement and process for amendments

Issues specific to the Drew Agreement negotiations:

- Designation of the sponsoring institution (DHS or the University)
- . Changes in the Drew Board of Trustees as outlined in the Satcher Report
- Establishment of a faculty practice plan or similar mechanism to improve the incentives for clinical care and teaching

DHS and Drew have appointed negotiating teams, have agreed on ground rules, and have begun weekly discussions. We have jointly reviewed demographic data within SPA 6 to ensure that our negotiations take place within a context of community health needs and the most rational future programmatic design for KDMC. We have begun to discuss the specific issues from attachment I.

In addition, Drew has formed working groups to address their Board structure and governance, faculty practice plan, and residency issues. The University of California is leading and contributing key members to a Drew GME Advisory Group targeting the structure of the GME Office, the ongoing education of the program directors, and the pre-review of reports to be submitted to the ACGME. The California Endowment has funded a project to examine the role and structure of the Drew Board of Trustees. The inter-relationships among the various work groups is shown schematically in Attachment II.

We have established a Steering Committee that includes our CEOs, Medical Directors, Finance Director, and selected members from County Counsel and CAO. This group will provide advice and support to Dr. Waters and his negotiating teams and will assist with the oversight of this process. The first meeting of this group took place on March 1, 2004.

Finally, while I am optimistic that we will be able to renegotiate our affiliation agreement with Drew, we are exploring addition options with regard to clinical care and training at KDMC. The options that we see as potentially viable and our plans are shown on Attachment III.

Please let me know if you would like to discuss further.

TLG:rlw

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors

Affiliation Agreement Negotiations

Between

Los Angeles County Department of Health Services (LADHS) Martin Luther King, Jr. Medical Center (KDMC)

R

Charles R. Drew University of Medicine and Science (Drew)

Key elements (Drew specific issues in italics)

1. Value of Services Provided and Incentives for Education and Clinical Care

- a. What is the contractual assurance that the incentives for faculty are clear and focused on clinical care and education at KDMC?
- b. What are financial incentives for clinical care and education?
- c. What are the measures of clinical productivity?
- d. What are the measures of educational productivity and effectiveness?
- e. Is physician compensation per unit of work reasonable for this geographic area?
- f. Does the current practice plan meet the intent of the Satcher Task Force goal of accountability and incentives for the academic and clinical mission?
- g. How are insured patients referred for care in non-LADHS?

2. Contract Oversight

- a. How will compliance with the agreement be monitored?
- b. What are the consequences for failure to adhere to the agreement?

3. Determination of Number of Residency Slots and Supported Programs

- a. Which programs will LADHS & Drew run?
- b. How many residency training slots will be allotted for those programs?
- c. How will future changes in programs or number of slots be determined?
- d. What additional considerations are necessary to meet RRC requirements?

4. Communications

- a. What are the commitments to communication and information sharing?
- b. What documents regarding the residency programs are shared? When? By whom?
- c. What structures or processes are or will be in place to assure ongoing, positive communication between LADHS and Dew?

5. Term of the Contract and Flexibility and Process for Amendments

- a. What is the term of the contract?
- b. How will future changes in the contract be made?

6. Sponsoring Institution

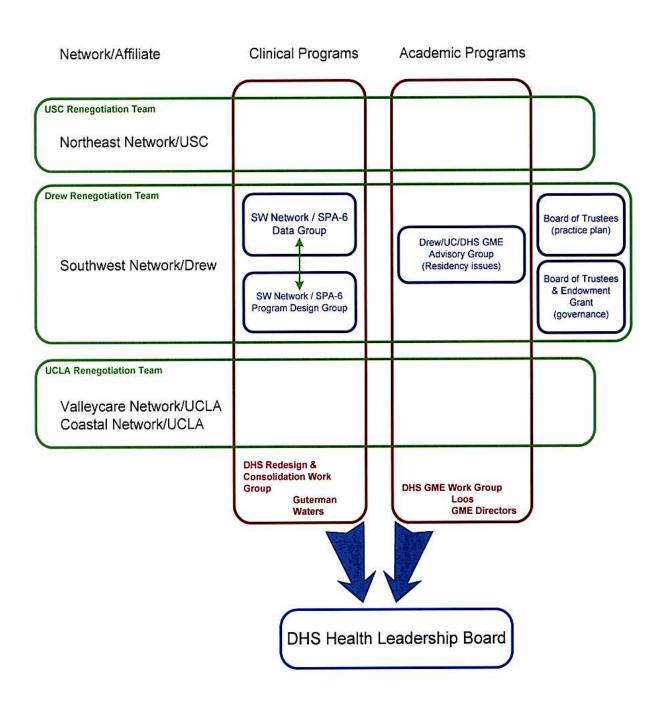
- a. Will the residency programs be sponsored by DHS or Drew?
- b. Do both parties understand the pros and cons for the decision?

7. Board of Trustees

- a. What are the stated functions and responsibilities for the Drew Board of Trustees?
- b. What are the skills and experiences needed for the Board to fulfill those functions and responsibilities?
- c. What is the evidence that the current Drew Board of Trustees has those skills and experiences and, if not, have changes been made?
- d. What are the structural commitments to a process for picking future Board members that assures future Boards will have the skills and experiences to fulfill their role?

Los Angeles County Department of Health Services

Clinical and Academic Program Redesign



Attachment III: Strategic Alternatives and Plans for DHS-Drew Affiliation



Drew University

- · Motivated to change
- New President and Board Chair show commitment
- · California Endowment Support
- University of California Support
- · Board Retreat
- · Mission is worthy
- Must align incentives
- Will take several years to rebuild programs & image



- · Move negotiations
- Push hard for fundamental improvements in the structure of the affiliation and the University

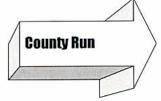


Another University

- UCLA & USC willing to help but have not been interested in operating these training programs
- Could enhance recruitment, especially with rotations to main campus
- Could evaluate and attract faculty

Plan:

- Continue to work and dialog with the Vice President for Health Affairs for University of California System
- Continue dialog with USC & UCLA



County-run Program

- · Cedars-Sinai type model
- Would require adding infrastructure to run the programs
- Transition would not be as hard as eliminating residents
- · Fewer programs
- Programs would struggle to compete for residents
- Faculty recruitment would be difficult

Plan:

- Explore models locally and nationally of successful residency training programs not affiliated with a medical school
- Define needed infrastructure and costs
- Continue Clinical Redesign of DHS to focus training programs on clinical needs



No residents

- Would need competitive salaries or can expect trouble attracting and keep high quality physician staff
- Would need to add ancillary staff to do work currently performed by residents

Plan:

- Review RFP's that have been sent out from DHS for contracted services for availability and price
- Review issues associated with non-affiliated public hospitals in other areas